



# ABC Pediatrics

## Twelve Month Pre-visit Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Bathes (daily) (every other day)

**Feeding Routine (circle one): Formula Feeding    Breast feeding    Whole Milk**

Drinking from Sippy cup or bottle? \_\_\_\_\_ Balanced Diet? \_\_\_\_\_ Picky eater? \_\_\_\_\_

Comments: \_\_\_\_\_

# of stools Daily \_\_\_\_\_ # of voids Daily \_\_\_\_\_

Type of water (bottled/well/city): \_\_\_\_\_ # of hours sleeping at ONE time \_\_\_\_\_

Current Dentist: \_\_\_\_\_ Current Daycare: \_\_\_\_\_

### Developmental Milestones (circle all that apply)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Crawls                          | <input type="checkbox"/> Drinks from a cup      | <input type="checkbox"/> Feeds self       | <input type="checkbox"/> Looks at pictures |
| <input type="checkbox"/> Pincer grasp<br>(thumb/pointer) | <input type="checkbox"/> Points to 2 body parts | <input type="checkbox"/> Says Mama/dada   | <input type="checkbox"/> Stands            |
| <input type="checkbox"/> Walks holding on                | <input type="checkbox"/> Waves Bye Bye          | <input type="checkbox"/> Plays Pat-a-cake | <input type="checkbox"/> Stranger Anxiety  |

**Lead Test Completed? YES NO**

**Any other questions or concerns you would like to discuss?**

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<b>TB Screen</b>	<b>Has a family member or contact been diagnosed with TB?</b>	<b>YES</b>	<b>NO</b>
	<b>Was your child born in a country at high risk for TB?</b>	<b>YES</b>	<b>NO</b>
	<b>Has your child traveled to a country at high risk for TB?</b>	<b>YES</b>	<b>NO</b>
<b>Lead Risk</b>	<b>Does your child have a sibling or playmate that has had lead poisoning?</b>	<b>YES</b>	<b>NO</b>
	<b>Does your child live in or regularly visit a home built before 1978 that being renovated?</b>	<b>YES</b>	<b>NO</b>
	<b>Does your child live in or regularly visit a house or childcare facility built before 1950?</b>	<b>YES</b>	<b>NO</b>

Weight \_\_\_\_\_ Temp \_\_\_\_\_ Height \_\_\_\_\_ Head Circumference \_\_\_\_\_ GoCheck \_\_\_\_\_